Arizona Regulatory Board of Physician Assistants

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258-5514
Telephone: 480-551-2700 • Fax: 480-551-2704 • www.azpa.gov

Janet Napolitano
Governor

Albert Ray Tuttle, P.A.-C
Chairman

Timothy Miller, J.D.
Executive Director

APPLICATION INSTRUCTIONS

An Application for licensure as a physician assistant and the accompanying materials are included with this document. Please read all instructions carefully, noting that it is ***YOUR RESPONSIBILITY*** for ensuring verification of your physician assistant training, PANCE eligibility, experience, and verification of P.A. certification/licensure/registration from other states. Please be sure all documents are forwarded directly to the Licensing Division of the Arizona Regulatory Board of Physician Assistants ("P.A. Board") at the address above. Applicants are required to comply with the current statutes and rules at the time they submit their application and should licensure be granted.

FOR YOUR INFORMATION:

Credentials submitted in foreign languages must be accompanied by a certified English translation.

All credentials submitted shall remain the property of the P.A. Board and will not be returned. *(Do not submit copies exceeding 8½" X 11" in size.)*

An application will not be considered for approval until all requisite forms and supporting documentation are in hand, which is your responsibility.

All forms provided in the application must be completed by the appropriate entity and returned directly to the P.A. Board's office.

A.R.S. § 32-2522 (G) mandates that failure to submit a completed application within one year from the date of the board's mailing to the applicant of a statement of application deficiencies will result in your application being withdrawn. A complete application includes ***ALL*** forms, documentation, examination scores, verifications, etc., requested by the board, submitted in a form satisfactory to the board. Therefore, an application is not considered complete (even though the application form itself is completed) until ALL of the requested information has been received by the Licensing Division.

PLEASE NOTE THAT APPLICATION FEES ARE NOT REFUNDABLE.

Your interest in licensure in Arizona is appreciated and the Licensing Division looks forward to working with you to successfully complete this process. Should you have any questions, please do not hesitate to contact the P.A. Board Licensing Division staff at 480-551-2700. Also, for further information you may visit our website at www.azpa.gov.

PLEASE NOTE: The Notification of Supervision application is a ***SEPARATE*** application from the Licensure application and requires its own fee of $125.00. A Physician Assistant may not perform health care tasks in Arizona until the Notification of Supervision is approved by the P.A. Board.

In addition to the appropriate completion of this application, the following must be submitted:
(please see the attached checklist for all documents needed)

1. Evidence of legal name and date of birth: photocopy of birth certificate or other documentary evidence, i.e., Passport, Visa, etc.
2. Evidence of legal name change other than that shown on documents filed in accordance with #1 above, i.e., marriage certificate.
3. Submit a complete and accurate statement of whereabouts and nature of practice, or other activities from the date of graduation from physician assistant training to the date of application, indicating the exact month and year for each. No period unaccounted for is allowed.
4. Submit all forms included with the application that are applicable and that are listed on the checklist.
5. Submit a check, money order, or the attached payment card authorization for the applicable non-refundable statutory fee

ADDITIONAL INSTRUCTIONS FOR QUESTIONS #9 and #17

If you are currently participating or have participated pursuant to A *CONFIDENTIAL AGREEMENT OR ORDER* in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol or drug abuse you may answer "NO" to these questions. If you do so, YOU MUST CONTACT THE BOARD'S COMPLIANCE OFFICE AT (480) 551-2716 or (1)(877) 255-2212 to arrange issuance of a CONFIDENTIAL ORDER FOR PARTICIPATION IN THE BOARD'S REHABILITATION PROGRAM.*

PLEASE NOTE: If you are in such a program pursuant to A PUBLIC ORDER, YOU MUST ANSWER "YES."

IF YOU HAVE QUESTIONS AS TO WHETHER THE PROGRAM YOU ARE PARTICIPATING IN QUALIFIES YOU TO ANSWER "NO" TO THIS QUESTION PLEASE CONTACT THE BOARD'S COMPLIANCE OFFICE.

FAILURE TO PROPERLY ANSWER THESE QUESTIONS OR DISCLOSE ALCOHOL OR SUBSTANCE ABUSE CAN RESULT IN BOARD DISCIPLINARY ACTION OR DENIAL OF A LICENSE.

***You will not automatically be placed in the Board's Program if you are not currently participating in another state's program.**

APPLICATION

FOR P.A. BOARD STAFF USE ONLY-DO NOT WRITE IN THIS SPACE

Application for:			**Date Rec'd:**
Regular License	$125.00	☐	_____
Temporary License	$ 50.00	☐	_____

To be completed and signed by applicant. All questions must be fully answered. (Type or Print responses)

1. Legal Name: _____
   (Last) (First) (Middle) (Maiden)

2. Office Address (if applicable): _____
   (No.) (Street) (City) (State) (Zip)

3. Name of Physician Assistant Training Program Attended: _____

   Location: _____ Degree Date: _____

4. In what states or provinces have you ever been granted any licensure as a physician assistant? If more than two, attach separate listing.

   (a) _____
   (State Board) (License No.) (Date Issued) (Status)

   (b) _____
   (State Board) (License No.) (Date Issued) (Status)

5. Have you ever had an application for licensure denied or rejected by another state/province licensing board? Yes ☐ No ☐

6. Have any actions, restrictions, limitations (including probation or academic probation) been taken while you were participating in any type of training program or by any health care provider? Yes ☐ No ☐

7. Have you ever been charged with a violation of any statute, rule or regulation of any domestic or foreign governmental agency? Yes ☐ No ☐

8. Have you ever been found guilty or entered into a plea of no contest to a felony or to a misdemeanor involving moral turpitude in any state: Yes ☐ No ☐

9. Have you ever had a license revoked, suspended, limited, restricted, placed on probation, voluntarily surrendered or canceled during an investigation or in lieu of disciplinary action, or entered into a consent agreement or stipulation? Yes ☐ No ☐

10. Have you ever had hospital privileges revoked, denied, suspended or restricted in any way? Yes ☐ No ☐

11. Have you ever been involved in any malpractice matter which resulted in a judgment or settlement against you in excess of $20,000.00? Yes ☐ No ☐

12. Have you ever been convicted of Medicare or Medicaid fraud or received sanctions (including restriction, suspension or removal from practice) imposed by an agency of the federal government? Yes ☐ No ☐

13. Has your ability to prescribe, dispense or administer medications ever been limited, restricted, modified, denied, surrendered or revoked by a federal or state agency? Yes ☐ No ☐

NOTE: In the event the response to questions 5 through 13 is "YES", you must file with the application, a detailed written narrative statement concerning the matter(s); including any charge(s), date of such charge(s), the complete name and address of all bodies of jurisdiction, the results of hearings, and the disposition of such charge(s). IN ADDITION, you must provide photocopy(ies) of any hearings, complaints, settlements or judgments, together with copy(ies) of patient's hospital and/or office records.

14. Are you presently in good physical and mental health? Yes ☐ No ☐ (If NO, you must file with this application, a detailed narrative statement of your health, diagnosis and prognosis and have your treating physician submit, directly to the board, a written statement to include your prognosis, diagnosis and recommendation for continuing care and treatment and a statement as to whether there is anything that would prevent you from safely performing health care tasks.)

15. Are you suffering from any ailment communicable to others? Yes ☐ No ☐ (If YES, you must file with this application, a detailed narrative statement of your health, diagnosis and prognosis and have your treating physician submit, directly to the board, a written statement to include your prognosis, diagnosis and recommendation for continuing care and treatment and a statement as to whether there is anything that would prevent you from safely performing health care tasks.)

16. Have you been counseled regarding your performance or behavior in any training program or by any health care provider? Yes ☐ No ☐ (If YES, you must file with the application a detailed written narrative statement including the name and address of the training program or health care provider, physician, preceptor, hospital/rehabilitation, etc. where you were counseled/treated and request that they send a full written narrative directly to the board.)

17. Do you have any disability, including alcohol or drug use, which may affect your ability to safely engage in the performance of health care tasks as a physician assistant? Yes ☐ No ☐

18. Have you ever taken a leave of absence, other than pregnancy, during your physician assistant training program, preceptorship training, or any other practice? Yes ☐ No ☐

NOTE: In the event the response to questions 17 or 18 is "YES", you must file with the application, a detailed written narrative concerning the above matter(s). You must request that the hospital/rehabilitation center(s), treating physician(s), or other health care provider(s) submit directly to the board a copy of your history and physical examination(s), consultation report(s), discharge summary(ies) from the hospital(s)/rehabilitation center(s), and a statement from your attending physician(s) or treating therapist(s) setting forth your diagnosis, prognosis and recommendations for continuing care, treatment and supervision and a statement as to whether there is anything that would prevent you from safely performing health care tasks.

19. Exact whereabouts and nature of practice or other activities from the date of graduation from school to the present, with the specific MONTH AND YEAR listed for each. NO PERIOD UNACCOUNTED FOR IS ALLOWED:

CITY	STATE	FROM/TO	NATURE OF ACTIVITY

The applicant _____
(Print or type Name)

being first duly sworn upon his oath deposes and says that I am the person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of Arizona, particularly those acts set forth in the Rules and Regulations of the Board. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentality's (local, state, federal or foreign) to release directly to the Arizona P.A. Board, all information, files, records requested by the P.A. Board in connection with the processing of this application. I further authorize the P.A. Board to release to the organizations, individuals and groups listed above any information which is material to my application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. I am the lawful holder of all credentials submitted and that the credentials submitted were not procured by fraud or misrepresentation or any mistake of which I am aware. Should I furnish false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my License to perform health care tasks as a physician assistant in the State of Arizona.

Signature of Applicant: _____ Date: _____

FOR P.A. BOARD STAFF USE ONLY - DO NOT WRITE IN THIS SPACE

Date application processed:	_____	Processed by:	_____
Date of Temporary approval:	_____	Approved by:	_____
Date Temporary License Issued:	_____	Temporary License No.:	_____
Date of Regular approval:	_____	Approved by:	_____
Date Regular License Issued:	_____	Regular License No.:	_____

ARIZONA **R**EGULATORY **B**OARD **O**F **P**HYSICIAN **A**SSISTANTS
9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

TEMPORARY LICENSE CHECKLIST

If you are registered with the N.C.C.P.A. for the examination and you are applying for a *TEMPORARY LICENSE*, please submit only those items listed below.

Applications submitted without the application fee will not be receipted or processed until the fee has been received. Your application cannot be approved until *ALL* documentation has been received.

Per *A.R.S. § 32-2522(G)* Failure to submit a completed application within one year from the date of the mailing by the board of a statement to the applicant of the deficiencies in the application pursuant to subsection E, will result in your application being withdrawn. ***Application fees are non-refundable.***

The following items are to be completed and forwarded to the board.

- ☐ $50.00 Application Fee for a Temporary License;
- ☐ Completed Application;
- ☐ Birth Certificate/Passport/Marriage License/Legal Name Change Documents;
- ☐ Copy of your P.A. Program Diploma;
- ☐ Home Address, Phone Number & Social Security Number Form (for our records only);
- ☐ Temporary License Agreement Form;
- ☐ Affidavit;
- ☐ Detailed written narrative statement if you answered YES to questions 5 through 18 on the application, and accompanying documentation.

The applicant must forward the following enclosed forms to the appropriate entity for completion.
(When completed by the entity, these are to be sent directly to the Arizona Regulatory Board of Physician Assistants.)

- ☐ Request a letter from the N.C.C.P.A. sent directly to the P.A. Board regarding your registration for the next examination;
- ☐ Form 1 to be completed and submitted by your P.A. Program

PLEASE NOTE THAT A TEMPORARY LICENSE IS ISSUED ONLY TO PHYSICIAN ASSISTANTS THAT ARE WAITING TO TAKE THE N.C.C.P.A. EXAMINATION.

ARIZONA **R**EGULATORY **B**OARD **O**F **P**HYSICIAN **A**SSISTANTS
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CONVERSION LICENSE CHECKLIST

If you are applying for a *CONVERSION OF YOUR TEMPORARY LICENSE TO A REGULAR LICENSE*, the following items must be submitted.

Written request for conversion submitted without the fee will not be receipted or processed until the fee has been received. Conversion approval cannot be approved until *ALL* documentation has been received.

The following items are to be forwarded to the board.

- ☐ $75.00 Fee;
- ☐ Written request for conversion of license;
- ☐ Employment List of all physician assistant employment held since graduation or during the past five years;

The applicant must forward the following enclosed forms to the appropriate entity for completion. (If applicable)
(When completed by the entity, these are to be sent directly to the Arizona Regulatory Board of Physician Assistants.)

- ☐ Medical Agency of Employment Form/Supervising Physician Form to be completed by all employers listed on the Employment List

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REGULAR LICENSE CHECKLIST

If you are applying for a *REGULAR LICENSE*, please submit all items listed below.

Applications submitted without the application fee will not be receipted or processed until the fee has been received. Your application cannot be approved until *ALL* documentation has been received.

Per *A.R.S. § 32-2522(G)* Failure to submit a completed application within one year from the date of the mailing by the board of a statement to the applicant of the deficiencies in the application pursuant to subsection E, will result in your application being withdrawn. ***Application fees are non-refundable.***

The following items are to be completed and forwarded to the board.

- ☐ $125.00 Application Fee for a Regular License;
- ☐ Completed Application;
- ☐ Birth Certificate/Passport/Marriage License/Legal Name Change Documents;
- ☐ Photocopy of your N.C.C.P.A. Certificate;
- ☐ Copy of your P.A. Program Diploma;
- ☐ Employment List of all physician assistant employment held since graduation or during the past five years;
- ☐ Home Address, Phone Number & Social Security Number Supplement Form;
- ☐ Affidavit;
- ☐ Detailed written narrative statement if you answered YES to questions 5 through 18 on the application and accompanying documentation.

The applicant must forward the following enclosed forms to the appropriate entity for completion. (If applicable)
(When completed by the entity, these are to be sent directly to the Arizona Regulatory Board of Physician Assistants.)

- ☐ Medical Agency of Employment Form/Supervising Physician Form to be completed by all employers listed on the Employment List;
- ☐ Form I to be completed and submitted by your P.A. Program;
- ☐ Verification of P.A. Certification/Licensure/Registration from other states

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HOME ADDRESS AND SOCIAL SECURITY SUPPLEMENT FORM

P.A. APPLICANT'S FULL NAME: _____

PLACE OF BIRTH: _____
(City) *(State)* *(Country)*

HOME ADDRESS: _____
(Street Address)

_____
(City) *(State)* *(Zip Code)*

HOME TELEPHONE NUMBER: ____( )_____
(Please include area code)

E-MAIL ADDRESS: _____

MAILING ADDRESS: _____
(Street Address)

_____
(City) *(State)* *(Zip Code)*

A.R.S. §32-2527(A): **In accordance with this statute, a residential address is not available to the public *unless* it is the only address of record.**

PLACE OF BIRTH: _____
(City) *(State)* *(Country)*

BIRTHDATE: _____ SOCIAL SECURITY NO: _____

A.R.S. §325-320 mandates that each licensing board or agency that issues professional or occupational licenses or certificates shall obtain and record the social security number of an applicant for a professional or occupational license or certificate.

CONFIDENTIAL INFORMATION – NOT FOR PUBLIC KNOWLEDGE

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AGREEMENT FOR TEMPORARY LICENSURE PURSUANT TO *A.R.S. §32-2524(F)*

Pursuant to ***A.R.S. §32-2524(F),*** this voluntary agreement is made between _____, P.A., and the Arizona Regulatory Board of Physician Assistants ("P.A. Board").

P.A. _____, holder of Temporary License no. _____ agrees and stipulates with the P.A. Board that he/she shall perform health care tasks under his/her Temporary License only at the same geographic work site where his/her supervising physician sees patients.

Any violation of this order constitutes unprofessional conduct as defined by ***A.R.S. §32-2501(18)(ee)*** and may result in disciplinary action pursuant to ***A.R.S. §32-2551***.

Arizona Regulatory Board
of Physician Assistants
of the State of Arizona

[S E A L]

_____
Timothy Miller, J.D., Executive Director

_____
Physician Assistant's Signature

Dated: _____

Dated: _____

Executed copy mailed this _____ day of _____, 2004 to the P.A.

_____
P.A. Board Staff Member

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AFFIDAVIT

STATE OF _____)

COUNTY OF _____)

I hereby certify that I have completely read, and will abide by the ARIZONA REVISED STATUTES pursuant to Chapter 25, and the RULES AND REGULATIONS pursuant to Chapter 17, governing the certification of physician assistants and the performance of health care tasks in the State of Arizona.

Dated this _____ day of _____, 20_____.

_____
(Print or Type full Name of Physician Assistant)

_____
(Signature of Physician Assistant)

NOTARY:

Sworn to before me this _____ day of _____, 20_____

_____
(Notary Signature)

My Commission Expires On: _____.

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258, Ph: 480-551-2700, Fax: 480-551-2704

FORM I – PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

Part of the application for certification as a physician assistant in the State of Arizona requires this form to be completed by the physician assistant training program where the physician assistant applicant received training as a physician assistant. The physician assistant applicant must forward this form for completion by an officer of the physician assistant training program which granted the physician assistant's degree.

I hereby authorize the release of all information in your files, favorable or otherwise, directly to: The Arizona Regulatory Board of Physician Assistants, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258.

_____ _____

(Physician Assistant Signature) (Printed/Typed Physician Assistant Name)

To Be Completed by the Physician Assistant Training Program:

This is to certify that _____ was granted the degree of

_____ on _____, 20_____.

The date of matriculation was _____, 20 _____.

NOTE: IF THE ANSWER IS YES TO ANY OF THE QUESTIONS, PLEASE ATTACH A WRITTEN EXPLANATION

1. Was the student ever required to repeat any segment of training? Yes ☐ No ☐

2. Were any actions, restrictions, limitation (including probation or academic probation) taken while the student was participating in your training program? Yes ☐ No ☐

3. Was the student ever counseled regarding his/her performance or behavior in your training program? Yes ☐ No ☐

4. Did the student have any medical condition which in any way impairs or limits his/her ability to safely practice any type of health care tasks within the scope of the physician assistant? Yes ☐ No ☐

- *["Ability to safely practice any type of health care tasks" is construed to include all of the following:*
- *The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and*
- *The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers, and,*
- *The physical capability to perform medical tasks such as physical examinations and other surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.*
- *"Medical Condition" includes any physiological, mental or psychological conditions or disorders, such as but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, drug addiction and alcoholism]*

5. To the best of your knowledge, within the last five (5) years, has the student been diagnosed with or treated for bi-polar disorder, schizophrenia, paranoia, or any psychotic disorder? Yes ☐ No ☐

6. To the best of your knowledge, has the student, since attaining the age of eighteen (18) or within the last five (5) years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia, or any psychotic disorder? Yes ☐ No ☐

7. Were the student's final evaluations in every category rated satisfactory and/or above? Yes ☐ No ☐
   If No, please attach a photocopy of the evaluation and a written explanation.

Signature: _____

Name & Title: _____ **[SEAL OF TRAINING PROGRAM]**
(If none, indicate so)

P.A. Program Name: _____

Address: _____

_____ **Date:** _____

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

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VERIFICATION OF CERTIFICATION/LICENSURE/REGISTRATION

Part of the application for licensure as a physician assistant in the State of Arizona requires that this form be completed by each state in which you hold or ever held certification, licensure, or registration as a physician assistant. I hereby authorize the release of all information in your files, favorable or otherwise, DIRECTLY to The Arizona Regulatory Board of Physician Assistants, 9545 E. Doubletree Ranch Rd., Scottsdale, AZ 85258.

Physician Assistant's Name: _____ _____ (Physician Assistant Signature)

Certification/Licensure/Registration Number: _____

THIS SECTION IS TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

STATE: _____

PHYSICIAN ASSISTANT NAME: _____

GRADUATE OF: _____

CERTIFICATE/LICENSURE/REGISTRATION NO.: _____ DATE ISSUED: _____

ENDORSEMENT WITH: _____

IS CERTIFICATION/LICENSURE/REGISTRATION CURRENT? YES ☐ NO ☐

IF NOT, WHY: _____

WAS THE APPLICANT'S CERTIFICATION/LICENSURE/REGISTRATION EVER REVOKED, SUSPENDED, LIMITED, RESTRICTED, PLACED ON PROBATION, VOLUNTARILY SURRENDERED OR CANCELED DURING AN INVESTIGATION OR IN LIEU OF DISCIPLINARY ACTION, OR ENTERED INTO A CONSENT AGREEMENT OR STIPULATION? YES ☐ NO ☐ IF YES, PLEASE ATTACH A WRITTEN EXPLANATION

DEROGATORY INFORMATION, IF ANY: _____

Signature of Official: _____ [BOARD SEAL] (If none, indicate so)

Printed Name of Official: _____

State Board: _____

Address: _____

_____ Date: _____

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

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MEDICAL AGENCY OF EMPLOYMENT/SUPERVISING PHYSICIAN FORM

Part of the application for certification as a physician assistant in the State of Arizona requires that this form be completed by ALL current and past Medical Agencies/Supervising Physicians where the applicant is or has been employed as a physician assistant for the past five (5) annual years.

MEDICAL AGENCY OF EMPLOYMENT/SUPERVISING PHYSICIAN: I hereby authorize the release of all information in your files, favorable or otherwise, directly to: The Arizona Regulatory Board of Physician Assistants, State of Arizona, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258.

_____ _____

(Physician Assistant Signature) (Printed/Typed Physician Assistant Name)

TO BE COMPLETED BY THE MEDICAL AGENCY OF EMPLOYMENT/SUPERVISING PHYSICIAN

NAME AND ADDRESS OF MEDICAL AGENCY/SUPERVISING PHYSICIAN: _____

_____

Dates of Employment: From: _____ To: _____

Names, locations and dates of each hospital/office/clinic wherein the physician was/is assigned: _____

_____

_____

1. Were any actions, restrictions, limitations (including probation) taken while in your employment? Yes ☐ No ☐
2. What health care tasks were extended to the applicant: _____
   _____
3. Were any limitations imposed on such health care tasks? Yes ☐ No ☐ If Yes, please explain: _____
   _____
4. Were any health care tasks ever removed or restricted? Yes ☐ No ☐ If Yes, please explain: _____
   _____
5. Derogatory information, if any: _____
   _____
6. Names of other medical agencies of employment or supervising physicians, if known (list name, city and state):
   1. _____
   2. _____
   3. _____
   4. _____

Signed: _____ [SEAL OR STAMP]
(If none, indicate so)

Name & Title: _____

Medical Agency/Supervising Physician: _____

_____

Address: _____

_____ Date: _____

ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

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PHYSICIAN ASSISTANT EMPLOYMENT LIST

APPLICANTS: List all current and/or previous employment with medical agencies/supervising physicians, i.e., physician assistant placement group, private practice, hospital, clinic, etc., for the past five (5) years, and return this form with your application.

If you have been in the military since graduating from a P.A. Program, do not have an Agency of Employment/Supervising Physician form completed. Have your Commanding Officer submit a letter providing the dates of active duty and anticipated date of release, along with a summary of your duties.

Physician Assistant Applicant's Name:____

Agency/Supervising Physician Name:____

Address:____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:____________________________TO:___________________________

Agency/Supervising Physician Name:____

Address:____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:____________________________TO:___________________________

Agency/Supervising Physician Name:____

Address:____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:____________________________TO:___________________________

Agency/Supervising Physician Name:____

Address:____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:____________________________TO:___________________________

Agency/Supervising Physician Name:____

Address:____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:____________________________TO:___________________________

Agency/Supervising Physician Name:____

Address:____

(CITY) *(STATE)* *(ZIP)*

Dates of Employment: FROM:____________________________TO:___________________________

(THIS FORM MAY BE COPIED IF THERE ARE ADDITIONAL EMPLOYERS)

Arizona Regulatory Board of Physicians Assistants

PAYMENT CARD AUTHORIZATION

PHYSICIAN ASSISTANT LICENSE APPLICATION FEE

Payment for: _____PA

Please check the appropriate fee:

☐ **REGULAR FEE $125** ☐ **TEMPORARY FEE $50** ☐ **CONVERSION FEE $75**

Type of Card: ☐ **Visa** ☐ **MasterCard**

Card #: ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Expiration Date: ☐☐-☐☐ **(MM-YY)**

Name as Shown on Payment Card: _____

Billing Address of Cardholder:
(Required**)**

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number of Cardholder: _____
(Required**)**

Mailing Address of Cardholder: (If different from billing address):

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature of Cardholder: _____ **Date:** _____

Please complete and return this form with your *Regular license application* if paying by credit card.
(If you fax your fee payment, please ***DO NOT*** *mail in the original form as you may be charged a second time. Thank you!)*

Fax Number: 480-551-2704

Mailing Address: Arizona Regulatory Board of Physician Assistants, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258

Revised 7/28/04